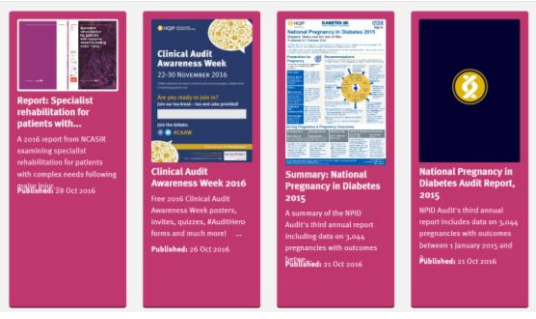
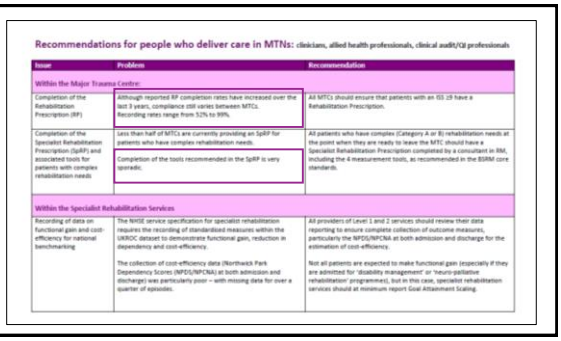
NCASRI update

Prof Lynne Turner Stokes

Who is funding the audit and why participate?

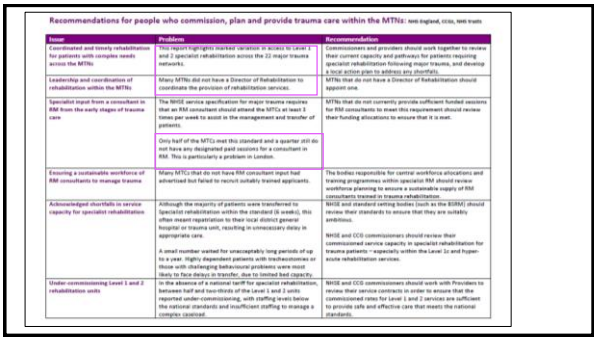
- The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices
- Its aim is to promote *quality improvement*, and in particular to *increase the impact that clinical audit has on healthcare quality* in England and Wales
- National Clinical Audit and Patient Outcomes Programme (NCAPOP) - covering the National Clinical Audit Programme and also the Clinical Outcome Review Programmes
- Funded by NHS England, the Welsh Government and, with some individual audits, also funded by the Health Department of the Scottish Government, DHSSPS Northern Ireland and the Channel Islands





Recommendations for people who deliver care in MTNs: clinicians, allied health professionals, clinical audit/QI professionals

Issue	Problem	Recommendation
Within the Major Trauma Centre:		
Completion of the Rehabilitation Prescription (RP)	Although reported RP completion rates have increased over the last 3 years, compliance still varies between MTCs. Recording rates range from 52% to 99%.	All MTCs should ensure that patients with an ISS ≥8 have a Rehabilitation Prescription.
Completion of the Specialist Rehabilitation Prescription (SpRP) and associated tools for patients with complex rehabilitation needs	Less than half of MTCs are currently providing an SpRP for patients who have complex rehabilitation needs.	All patients who have complex (Category A or B) rehabilitation needs at the point when they are ready to leave the MTC should have a Specialist Rehabilitation Prescription completed by a consultant in RM, including the 4 measurement tools, as recommended in the BSRM core standards.
	Completion of the tools recommended in the SpRP is very sporadic.	
Within the Specialist Rehabilitation Services		
Recording of data on functional gain and cost-efficiency for national benchmarking	The NHSE service specification for specialist rehabilitation requires the recording of standardised measures within the UKROC dataset to demonstrate functional gain, reduction in dependency and cost-efficiency. The collection of cost-efficiency data (Northwick Park Dependency Scores (NPDS/NPCNA) at both admission and discharge) was particularly poor – with missing data for over a quarter of episodes.	All providers of Level 1 and 2 services should review their data reporting to ensure complete collection of outcome measures, particularly the NPDS/NPCNA at both admission and discharge for the estimation of cost-efficiency. Not all patients are expected to make functional gain (especially if they are admitted for 'disability management' or 'neuro-palliative rehabilitation' programmes), but in this case, specialist rehabilitation services should at minimum report Goal Attainment Scaling.



Recommendations for people who commission, plan and provide trauma care within the MTNs: NHS England, CCGs, NHS trusts

Issue	Problem	Recommendation
Coordinated and timely rehabilitation for patients with complex needs across the MTNs	This report highlights marked variation in access to Level 1 and 2 specialist rehabilitation across the 22 major trauma networks.	Commissioners and providers should work together to review their current capacity and pathways for patients requiring specialist rehabilitation following major trauma, and develop a local action plan to address any shortfalls.
Leadership and coordination of rehabilitation within the MTNs	Many MTNs did not have a Director of Rehabilitation to coordinate the provision of rehabilitation services.	MTNs that do not have a Director of Rehabilitation should appoint one.
Specialist input from a consultant in RM from the early stages of trauma care	The NHSE service specification for major trauma requires that an RM consultant should attend the MTCs at least 3 times per week to assist in the management and transfer of patients. Only half of the MTCs met this standard and a quarter still do not have any designated paid sessions for a consultant in RM. This is particularly a problem in London.	MTNs that do not currently provide sufficient funded sessions for RM consultants to meet this requirement should review their funding allocations to ensure that it is met.
Ensuring a sustainable workforce of RM consultants to manage trauma	Many MTCs that do not have RM consultant input had advertised but failed to recruit suitably trained applicants.	The bodies responsible for central workforce allocations and training programmes within specialist RM should review workforce planning to ensure a sustainable supply of RM consultants trained in trauma rehabilitation.
Acknowledged shortfalls in service capacity for specialist rehabilitation	Although the majority of patients were transferred to Specialist rehabilitation within the standard (6 weeks), this often meant repatriation to their local district general hospital or trauma unit, resulting in unnecessary delay in appropriate care. A small number waited for unacceptably long periods of up to a year. Highly dependent patients with tracheostomies or those with challenging behavioural problems were most likely to face delays in transfer, due to limited bed capacity.	NHSE and standard setting bodies (such as the BSRM) should review their standards to ensure that they are suitably ambitious. NHSE and CCG commissioners should review their commissioned service capacity in specialist rehabilitation for trauma patients – especially within the Level 1c and hyper-acute rehabilitation services.
Under-commissioning Level 1 and 2 rehabilitation units	In the absence of a national tariff for specialist rehabilitation, between half and two-thirds of the Level 1 and 2 units reported under-commissioning, with staffing levels below the national standards and insufficient staffing to manage a complex caseload.	NHSE and CCG commissioners should work with Providers to review their service contracts in order to ensure that the commissioned rates for Level 1 and 2 services are sufficient to provide safe and effective care that meets the national standards.

Progress after 18 months

- Unmet need identified in round 1
- We need to reinforce there is a problem of unmet need in the prospective audit
- Importance of identifying ALL patients with category A/B needs in the MTCs in order to identify the need
- We continue to find ways to help people to do this
  - Data collection methods

Network	MTC	Method
Northern (Cumbria)	Royal Victoria Infirmary Newcastle	TARN
Northern (North East)	James Cook University Hospital Middlesborough	TARN
West Yorkshire	Leeds General Infirmary	N/A
North Yorkshire & Humberside	Hull Royal Infirmary	TARN
Lancashire & South Cumbria	Royal Preston Hospital	Paper
Greater Manchester	Manchester collaborative MTC	UKROC/ TARN
Cheshire and Merseyside	Liverpool Collaborative MTC	ORION
South Yorkshire	Northern General Hospital Sheffield Royal Hallamshire Hospital	Paper/TARN
NW Midlands & North Wales	University Hospital of North Staffordshire	Own system
Birmingham BC, Hereford & Worcs	Queen Elizabeth Hospital Birmingham	TARN
Central England	University Hospital Coventry	TARN
East Midlands	Queen's Medical Centre Nottingham	TARN
East of England	Addenbrookes, Cambridge	ORION
Thames Valley	John Radcliffe Hospital Oxford	N/A
Severn	Southmead Hospital	TARN
North West London	Hillingdon Hospital St Mary's Hospital London (Paddington)	Paper
North East London and Essex	Royal London Hospital	TARN
South West London and Surrey	St George's Hospital London	Paper
South East London Kent & Medway	King's College Hospital London	Paper
Sussex	Royal Sussex County Hospital Brighton	ORION
Wessex	Southampton General Hospital	Paper

Progress after 18 months

- Prospective data collection commenced in July
- Slow start but getting some data via TARN and ORION
- Section 251
- Importance of identifying ALL patients with category A/B needs in the MTCs regardless of where they are referred to or transferred to
- When patient is ready for rehabilitation

Thank you

- Any questions: Karenhoffman@nhs.net
- http://www.kcl.ac.uk/lsm/research/divisions/cicelysaunders/about/rehabilitation/National-Clinical-Audit-.aspx